SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May

HOME NAME : Pinecrest

People who participated development of this report

	Name	Designation
Quality Improvement Lead	Caroline Guimond	ED
Director of Care	Bridget Lahaie	DOC
Executive Directive	Caroline Guimond	ED
Nutrition Manager	Vacant	Vacant
Life Enrichment Manager	Vacant	Vacant

Summary of the Home's priority areas for quality improvement, objectives, policies, procedures and protocols from previous year (2022/2023): What actions were completed? Include dates and outcomes of actions.

Quality Improvement Objective	Policies, procedures and protocols used to achieve quality improvement	Outcomes of Actions, including dates
Decrease the percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	Policies, procedures and protocols: - 24-Hour Report - Medication management - Medication Review - Responsive behaviours/BSO	Outcome:32.96% Date:30/11/2023
Decrease the percentage of avoidable emergency department visits	Policies, procedures and protocols: - Admission - Advance Care Planning - Interdisciplinary Assessment - Advance care planning patient workbook - My wishes program	Outcome:13.6% Date:30/11/2023
Increase the percentage of residents who responded positively to the statement: "I can express my option without fear of consequence" in the annual resident satisfaction survey.	Policies, procedures and protocols: - Zero tolerance of Resident Abuse and Neglect - Commitment to resident-centered care and resident rights	Outcome: 81.94% Date: 30/11/2023

How Annual Quality Initiatives Are Selected

The continuous quality improvement initiative is aligned with our mission to provide quality care and services through innovation and excellence. The home has a Continuous Quality Improvement Committee comprised of interdisciplinary representatives that are the home's quality and safety culture champions. An analysis of quality indicator performance with provincial benchmarks for quality indicators is completed. Quality indicators below benchmarks and that hold high value on resident quality of life and safety are selected as a part of the annual quality initiative. Emergent issues internally are reviewed for trends and inccorporated into initiative planning. The quality initiative is developed with the voice of our residents/families/POA's/SDM's through participation in our annual resident and family satisfaction survey and as members of our continuous quality improvement committee. The program on continuous quality improvement follows our policies based on evidence based best practice.

Summary of Resident and Family Satisfaction Survey for Previous Fiscal Year	
Date Resident/Family Survey Completed for 2022/23 year:	The 2023 resident and family surveys were conducted from October 2nd to October 17th, 2023.
Results of the Survey (*provide description of the results*):	In 2023, several significant improvements were observed, when compared to the previous year. For example, the percentage of families who were satisfied with the care provided to residents increased by over 20% (87% compared to 67%). Overall, 87% of residents and 89% of families would recommend Pinecrest Nursing Home to others. The opportunities for improvement that were identified most frequently were related to incontinence products, laundry services and care conferences.
How and when the results of the survey were communicated to the Residents and their Families (including Resident's Council, Family Council, and Staff)	A summary of the satisfaction survey results are posted on the public bulletin board, which is located in a conspicuous area of the Home. The results were shared with the resident council on December 12, 2023 and the feedback provided was integrated into the action plan for the survey.

Summary of quality initiatives for 2023/24: Provide a summary of the initiatives for this year including current performance, target and change ideas.		
Initiative	**Target/Change Idea**	**Current Performance**
Initiative #1 -'Decrease the percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	TARGET: 21.14% CHANGE IDEAS: 1) Provide education to staff on documentation of responsive behaviours such as hallucination and dellusion. 2) Review an verify the data on the number of residents prescribeds antipsychotics, including new starts, prns, and administration rates. Identify residents using antipsychotic medications who could potentially use alternative medications. Check for underlying infections. 3) The Home will collaborate with BSO, MD, NP and pharmacy consultant to : i) review MDS Outcome scores (CPS, ABS, and Pain), ii) discuss and consider use of alternative medication such as naturopathic or cannabis based on the current diagnosis. iii) review and assess alternative medication based on current diagnosis and health condition, and iv) health conditions of residents using antipsychotic medication without the supporting diagnosis;	32.96%
Initiative #2 - 'Decrease the percentage of avoidable emergency department visits	TARGET: 12.5% CHANGE IDEAS: 1) Support early recognition of residents at risk for ED visits; 2) At admission and updated yearly, discuss end-of-life and do-not-resuscitate (DNR) orders to ensure LTC residents, families, and caregivers are provided education around end-of-life care and that their wishes are documented; 3)Educate residents and family during admission and resident/family council meeting of reducing ED visits; 4) Review and update Advance Care Directives annually with families at care conferences, providing education on hospital transfers and impact on residents 5) Home is utilizing MD for advice prior to sending residents to hospital.	14%

Initiative #3 - 'Increase the percentage of residents who responded positively to the statement: "I can express my option without fear of consequence" in the annual resident satisfaction survey.	TARGET: 78.00% CHANGE IDEAS: 1) Develop mechanisms to ensure that the resident council is meeting at a frequency prescribed by the Act or more frequently. During Resident Council meetings, provide the members with opportunities to discuss and provide input on a variety of areas that impact their care and wellbeing. 2) Provide education to the resident council regarding the process for making a complaint, as well as escalating a complaint that has not been addressed. 3) Ensure that Surge training on the Bill of Resident Rights is maintained at 100% consistantly throughout the year; 4)Improve the staff orientation to enclude more information on the bill of resident rights, and the process for addressing resident complaints.	81.94%
Initiative #4 - Reduce the percentage of worsening stage 2-4 pressure ulcers.	TARGET: 1.48% CHANGE IDEAS: 1) DOC or delegate to review Skin and Wound Program: Wound Care Management RC-23-01-02 , including RD referral process. 2) Identify a Wound Care Lead. The Wound care lead will ; a) Monitor weekly (or as required) existing and new skin breakdown, pressure injuries, skin tears or wounds in PCC. b) Ensure referrals to the RD are timely submitted and processed as per policy c) Review skin issues at management meetings 3) Review: SBAR (Situation, Background, Assessment/ Appearance, Recommendation) with all Reg. Staff - RC-12-01-05 and completion in PCC. 4) DOC to organize educational sessions on Skin and Wound Program: Wound Care Management RC-23-01-02 (with emphasis on documentation and care planning) with all Reg staff, including agency staff	1.54%